SUMMARY

Oklahoma's goal is to provide creditable health insurance coverage for uninsured children in the state through its State Children's Health Insurance Program (SCHIP). The state's Children's Health Insurance Program is implemented through a Medicaid expansion, which became effective December 1, 1997. SCHIP eligibles are enrolled in either SoonerCare Plus or SoonerCare Choice – Oklahoma's Medicaid managed care programs.

Oklahoma implemented a number of strategies aimed at improving access and enrollment in SoonerCare. It eliminated the asset test, simplified the application (from 8 pages front and back to 1 page front and back), and launched an aggressive marketing and outreach campaign. The nature of these outreach activities has created a paradigm shift- moving the social workers from their traditional roles as eligibility workers to mechanisms of social change. They are encouraged to actively seek out children and link them to health care services, and build partnerships within their communities. However, there is a recognizable need for ongoing coordination between the public and private sector efforts. In terms of health care, the public dialogue has been established and continues to be refined. Major long-term considerations for outreach efforts include: local communities have adequate support, local outreach initiatives are working in concert with one another, reduce duplication of effort, maximize "Lessons Learned", develop ongoing dialogue and information sharing, and tracking of outreach mechanisms and their effectiveness, emphasis on public/private partnerships.

The state is pleased to report that we have 17,521 SCHIP eligible children (out of 40,995) enrolled in SoonerCare (at the end of FFY 1998) which is 43% of total SCHIP eligibles. While the state is very pleased at the progress made in enrolling SCHIP children in SoonerCare, we remain fully committed to making strong efforts to enroll the rest of the eligible children currently not enrolled in the program. This reports concludes with some concerns that Oklahoma has with several provisions of SCHIP legislation that make it difficult for the state to successfully implement it; also included are some proposed approaches to address such problems.

II. INTRODUCTION

Oklahoma's goal is to provide creditable health insurance coverage for uninsured children in the state through its State Children's Health Insurance Program (SCHIP). The state's Children's Health Insurance Program is implemented through a Medicaid expansion, which became effective December 1, 1997. SCHIP eligibles are enrolled in either SoonerCare Plus or SoonerCare Choice – Oklahoma's Medicaid managed care programs.This annual report covers the period for FFY 1998 from December 1, 1997 to September 30, 1998.

Oklahoma implemented a number of strategies aimed at improving access and enrollment in SoonerCare. It eliminated the asset test, simplified the application (from 8 pages front

and back to 1 page front and back), and launched an aggressive marketing and outreach campaign. Systems modifications were implemented (effective 12/1/1997) in order to ensure that eligible targeted low-income children under SCHIP would be separately identified and reported. Individuals who are eligible for Medicaid are promptly enrolled in Medicaid and the enhanced funding under SCHIP will only be claimed for eligible targeted low-income children who do not have creditable health insurance coverage and are not eligible for Medicaid.

Outreach Initiatives: Since the inception of Title XXI, Oklahoma recognized that outreach and education would be a critical component in getting needy children linked to necessary health care services. In an effort to meet the objectives established by the President, Congress and the Department of Health and Human Services, the Oklahoma Health Care Authority has aggressively pursued the development and implementation of outreach activities designed to increase awareness of its SoonerCare programs. Further, the OHCA's mass media and print endeavors have been designed to compliment the outreach activities implemented by local communities and county Department of Human Services Offices.

The overall objectives of outreach initiatives are: to reduce the number of uninsured children in Oklahoma through established mechanisms of health care delivery, to enhance and support local, community-based outreach initiatives, to provide increased access to primary health care services -- resulting in healthier Oklahomans. Collaborating Agencies include: Department of Human Services (DHS), Oklahoma State Department of Health (OSDH), Oklahoma Health Care Authority, Oklahoma Commission on Children and Youth (OCCY). Outreach priorities and development resulted from these state agency partnerships; each agency committed resources and programs to the outreach effort. Responsibilities were outlined through a series of outreach task force meetings and prior experiences with outreach were shared in order to focus on the most effective communication mechanisms. Some innovative approaches to serve community needs include: increased offices hours, outstationing of workers, attendance at special events, community development & awareness, speaking engagements, coordination with public schools.

The Oklahoma Health Care Authority designed, developed & produced fact sheets, flyers, posters and postcards, public service announcements for radio and television, and theater public service announcements. Examples of some current outreach efforts include:

Statewide television & radio promotion

Contract with the Oklahoma association of broadcasters (OAB) in development of public education partnership (PEP) – thirty (30) sec. spot

Statewide distribution to approximately 130 radio and television stations

Station participation is voluntary

Fixed contract amount with substantial return in exposure versus dollars invested

Statewide theater promotion

Contract with the national cinema network for the placement of public service slides

27 theaters statewide (127 screens)

Average weekly spots shown = 18,375

Average weekly attendance = 227,500

Total reach = approximately 5,900,000 individuals over a twenty-six week period

Statewide newspaper promotion

Contract with the Oklahoma Press Association (OPA) in development and placement of outreach promotion in 83 “legal” newspapers statewide.

Average circulation = 735,188

Total promotional insertions under contract = 14,703,760 (not counting “ink-kind” efforts)

Maximized “special” discounts

PSAs and press releases also provided with paid spots as an “in-kind” contributions by publishers

Statewide dissemination of printed material

Flyers

Posters

Postcards

Fact sheets

(approx. 1 million pieces of information printed & disseminated)

The following are contracts that are due to be re-bid for SFY 1999 in order to provide ongoing mass media outreach and education related to Title XXI and SB 639. The contracts are specific to the OHCA’s newspaper and theater advertising.

Outreach Contract Proposals for SFY 1999

Newspaper Advertising

SFY 1998:

Vendor:	Oklahoma Press Association
Contract Amount:	$141,407.00
Contract Period:	1-27-98 to 6-30-98

This contract enabled the OHCA to place newspaper advertising (1/8" page) in all legal newspapers on a statewide basis through a single procurement. The circulation reached under this contract was 14,703,760.

Circulation

Avg.circulation	735,188	
Flight (4 Insertions)*	2,171,836	(735,188 X4) – (768,916*)
X 5 flights	14,703,760	(2,940,752 X 5)
Avg. unit cost per flight	$0.03	

* Daily Oklahoman & Tulsa World only provide for two insertions per flight. 768,916 reflects the circulation of two insertions in these newspapers.

SFY 1999:

Vendor:	Oklahoma Press Association
Contract Amount:	$200,000.00*
Contract Period:	08-01-98 to 6-30-99

*The increase in encumbrance is to accommodate full fiscal year usage and rate changes for SFY 1999. It is recognized that the amount will not provide for the same frequency and circulation as in the SFY 1998 contract.

Theater Advertising

SFY 1998:

Vendor:	National Cinema Network
Contract Amount:	$55,679.02*

Contract Period: 12-29-97 to 6-30-98

* The initial contract was established for $100,000.00, but was prorated to reflect partial fiscal year usage.

This contract enabled the OHCA to place public service announcement slides in theaters on a statewide basis.

Number of Theaters: 27

Number of Screens: 175

Avg. Weekly Spots Shown: 18,375

Average Weekly Attendance: 227,500 (X 26 Weeks: 5,915,000)

Unit Cost $0.12 ($55,679.02 ÷ [18,375 X 26])

SFY 1999:

Vendor: National Cinema Network

Contract Amount: $100,000.00*

Contract Period: 08-01-98 to 6-30-99

*The increase in encumbrance is to accommodate full fiscal year usage and rate changes for SFY 1999.

In the last few months, a number of meetings have been held with American Indian tribes in collaboration with the Oklahoma Health Care Authority (OHCA) in efforts to conduct outreach to American Indians regarding the Children's Health Insurance Program (CHIP). Examples of these meetings are included below: On October 30, 1998, a meeting was held at the Citizen Pottawatomie Tribal Headquarters in Shawnee, Oklahoma between the OHCA and representatives from the Citizen Pottawatomie, Cherokee, Choctaw, Chickasaw and Wyandotte tribes. On November 17, 1998, a radio station interview was broadcast on a tribal radio station network. This interview with OHCA staff was conducted to make tribal members aware of SCHIP issues, eligibility for SCHIP, and in order to provide an effective way for tribal members to reach OHCA staff if they have questions or need more information. On November 23, 1998, a meeting was held at the Indian Health Services (IHS) Headquarters in Oklahoma City between representatives from their facilities and the OHCA. A meeting to discuss tribal issues is currently being organized for January 1999. We are also in negotiations to include tribal providers as primary care providers/case managers for the SoonerCare Choice program.

The OHCA authorized $2.5 million in federal funds to Department of Human Services; DHS will hire 46 workers designated solely for outreach- they will coordinate and assist in all the State's outreach efforts. These staff will also be dedicated to the Federally Qualified Health Centers at one-half time, will conduct one-on-one outreach in homes, and will train other entities in taking applications. Additional activities include: OHCA has been designated by HCFA as a pilot outreach site for its Native American population, OHCA is working with OCCY in the development of two rural pilot communities to demonstrate innovative "grass roots" outreach strategies (local community emphasis in design). In addition, OHCA is collaborating with the Oklahoma Institute for Child Advocacy in the application for a Robert Wood Johnson grant "The Oklahoma Covering Kids Initiative". OHCA is also investigating additional outreach mechanisms such as outdoor promotion on billboards, park benches, mass transit promotion (buses, bus shelters).

The nature of these outreach activities has created a paradigm shift- moving the social workers from their traditional roles as eligibility workers to mechanisms of social change. They are encouraged to actively seek out children and link them to health care services, and build partnerships within their communities. However, there is a recognizable need for ongoing coordination between the public and private sector efforts. In terms of health care, the public dialogue has been established and continues to be refined. Major long-term considerations for outreach efforts include: local communities have adequate support, local outreach initiatives are working in concert with one another, reduce duplication of effort, maximize "Lessons Learned", develop ongoing dialogue and information sharing, and tracking of outreach mechanisms and their effectiveness, emphasis on public/private partnerships.

III: STRATEGIC OBJECTIVES AND PERFORMANCE GOALS:

By the end of FFY 1998, the state hoped to have 45% of the newly eligible uninsured children enrolled (see attachment A for baseline uninsured data estimates –these were also included in the State Plan as attachment A). Between December 1997 and September 1998, Oklahoma had enrolled 47,504 children in SoonerCare. Out of 47,504 children an estimated number of 27,000 prior Medicaid eligible children (eligible before the expansion) have been enrolled in SoonerCare which brings Oklahoma's participation rate for that population up to approximately 76% (national average is 75%). The remaining 20,172 (out of 47,504 currently enrolled) children enrolled are newly eligible children.

Of the newly enrolled children eligible after the expansion 2,651 (13%) children have insurance, while 17,521 (87%) do not have insurance. The state is very pleased to report that we have 17,521 SCHIP eligible children enrolled in SoonerCare (at the end of FFY 1998) which is 43% of total SCHIP eligibles.

An estimated number of 27,000 prior Medicaid eligible children (before the expansion) have also been enrolled in SoonerCare which brings Oklahoma's participation rate for that population up to approximately 76% (national average is 75%).

3. Due to system constraints, the state was able to identify the children enrolled in the SCHIP only recently. Hence, in FFY 1998 the state has been unable to survey SCHIP enrollees in order to monitor crowd out. Since SCHIP does not cover children over 185% of the Federal Poverty Level, Oklahoma does not anticipate that crowd out will be a significant problem. However the state fully intends to develop several measures aimed at identifying the existence of crowd out. In the short run, Oklahoma plans to develop a statistically valid survey instrument. The state will survey SCHIP enrollees in order to determine if they dropped private health insurance coverage in the last three months prior to enrollment in SCHIP, and assess the reasons for dropping coverage. Crowd out will be defined as "dropping private health insurance coverage for reasons such as if the employer discontinues coverage, parents voluntarily discontinue coverage for their children due to high premiums for private coverage/better benefits under SCHIP etc". However if health insurance coverage was lost because the parents are no longer employed, or if current employer does not offer insurance etc.- these reasons will not constitute crowd out.

In the long run, the state intends to modify its simplified Medicaid application form in order to collect information necessary to analyze the existence of crowd out. The application form will be modified to incorporate applicable questions from the survey instrument. In addition, in consultation with HCFA, the state will try to define the level of crowd out (maybe as a percentage threshold level) that would trigger any corrective action that HCFA might recommend.

4. Through effective outreach, the state hoped to ensure that the enrollment (participation) percentages are the same for both the rural SoonerCare Choice and urban SoonerCare Plus programs by the end of FFY 1999. Before the expansion (November 1997), there were122,179 enrollees in SoonerCare - 74,170 (61%) enrollees in SoonerCare Plus and 48,009 (39%) enrollees in SoonerCare Choice. After implementing the expansion (September 1998) the number of enrollees in SoonerCare had increased to 148,504 – 80,117 (54%) enrollees in SoonerCare Plus and 68,387 (46%) enrollees in SoonerCare Choice. An analysis of the total estimated number of eligibles in both areas reveals that before the expansion (November 1997), approximately 39% of the SoonerCare Plus eligibles were enrolled in the program while 37% of the SoonerCare Choice eligibles were enrolled in the program. After implementing the expansion (September 1998) approximately 33% of the SoonerCare Plus eligibles were enrolled in the program while 41% of the SoonerCare Choice eligibles were enrolled in the program. As evident from the above numbers, the state is pleased to report that extensive outreach in the SoonerCare Choice areas has already resulted in a considerable increase in the enrollment numbers in those areas. The state will continue to focus it outreach efforts so that the cumulative enrollment percentages for the urban and rural areas will be about the same by the end of FFY 1999. Oklahoma seems well poised to achieve its goal of ensuring effective statewide participation in the expansion.

Oklahoma will monitor whether effective outreach has resulted in reductions in after the fact enrollments (retroactive eligibility) by the end of FFY 1999.

Oklahoma is pleased to report that through effective outreach and recipient and eligibility education programs, enrollment autoassignment rates have been reduced to between 40%-46% (for SoonerCare Choice) and between 50%-56% (for SoonerCare Plus). Prior to the expansion autoassignment rates varied between 39.24 and 88.61%.

IV: CONCLUDING REMARKS:

Oklahoma realizes that SCHIP presents a historic opportunity to reduce the significant number of uninsured children in the state. However several provisions of SCHIP make it difficult for the state to successfully implement it. The Federal allotment under SCHIP(in the initial years) is based on the numbers of uninsured children in the states at or below 200% of the Federal Poverty Level. However if an uninsured child is eligible for Medicaid, he/she is required to be enrolled in Medicaid and is ineligible for SCHIP. Therefore states with high numbers of prior Medicaid eligible uninsured children (like Oklahoma) will never be able to access all of their federal allotment in order to enroll this traditionally hard to reach population; at the same time SCHIP holds states accountable for enrolling them.

One of the biggest obstacles that Oklahoma will face in accessing all the SCHIP funds is that most of the uninsured children in the state are eligible for Medicaid and thereby ineligible for coverage under SCHIP. From December 1997 to September 1998, approximately 47,504 children were enrolled in SoonerCare. A majority of these children (63%) are eligible for Medicaid and only 27% are eligible for SCHIP. Our enrollment numbers confirm our concerns that even after spending the maximum 10% of federal SCHIP funds on administrative costs (including outreach), Oklahoma is going to have great difficulty in spending its federal allotment. It would be our recommendation that the use of SCHIP allotments be extended to cover Medicaid eligible children, because the promotion of SCHIP will bring additional Medicaid eligible children onto the rolls. As a result some states may have no incentive to increase outreach efforts. If the higher SCHIP rates were available to states that successfully enroll new children into either Medicaid or SCHIP, states could adopt more effective outreach programs without fear of harming their budgets.

While Oklahoma had assured HCFA in its Title XXI State Plan that it would comply with future reporting requirements as they are developed, the state was not aware how onerous the reporting requirements would be at that time. Oklahoma had expected more modest reporting requirements for SCHIP since states are also struggling at this time to comply with other federally mandated systems issues under the Balanced Budget Act of 1997 (e.g. MSIS, EDI, as well as Y2K). At this point it is unlikely that Oklahoma will be able to fully comply with either the annual reporting requirements or the state evaluations required under the deadlines established by SCHIP. We urge some relaxation of these

deadlines in order to allow states to use their limited resources to enroll eligible children in the program.

Another barrier to implementing SCHIP is the 10% restriction on the use of federal funds for direct services, administrative costs, and outreach activities. Since SCHIP holds states accountable for enrolling Medicaid eligible children in Medicaid (traditionally hard to reach population) it is our recommendation that the 10% be based on the total federal allotment, and not just on SCHIP program expenditures. This would greatly enhance states' abilities to implement creative outreach activities for both Medicaid and SCHIP populations especially in the first few years of the SCHIP program.

Welfare reform inadvertently has resulted in some vulnerable TANF recipients losing Medicaid coverage, which may lead to an increase in the numbers of uninsured. It has been administratively burdensome for the states to access these funds. We are aware that that this is of particular concern to HCFA; hence we would again urge an extension of the time limit of these TANF funds along with some flexibility in the use of these funds for additional outreach etc.

There also needs to be closer coordination in state and federal entities' efforts to enroll SCHIP eligible children. Federal entities need to inform their state counterparts of any new initiatives in order to prevent overlapping of efforts or, worse, impediments in local initiatives. A couple of examples will illustrate our point. Some months ago, the U.S. Department of Agriculture's Food and Nutrition Services sent a informational package on SCHIP to its regional counterparts without making any attempt to contact the state agency administering SCHIP (OHCA). This resulted in major chaos in the state as unfamiliar material was circulated without OHCA's knowledge. The unfamiliar terminology and incorrect contact number in these materials created major problems, which we are still trying to rectify. A similar incident with the Administration on Children and Families (ACF) also resulted in some setbacks of local outreach efforts.

Oklahoma remains fully committed to identifying eligible children for SCHIP and getting them enrolled in SoonerCare. In order to further reduce barriers to successful enrollment, Oklahoma revised eligibility rules (effective 2/1/1999) to simplify the application and enrollment process. Eligibility rules have been revised to establish a new eligibility process that applies specifically to categorically needy pregnant women and families with children that allows: (1) the client's statement/declaration to serve as income verification; (2) an eligibility re-determination process eliminating the automatic case closure at the end of the certification period; and (3) the initial six month eligibility period to consist of the current month and five months forward plus one, two or three months of retroactive eligibility (up to a nine month certification period). Currently, eligibility rules require verification of all income for the eligibility determination. For categorically needy (income under 185% of the Federal Poverty Level) pregnant women and families with children, the new rules will allow, unless questionable, the client's statement/declaration to serve as proof of income. Currently, rules require categorically needy families with children who do not receive cash assistance to be certified for Medicaid for a six-month period. The eligibility period terminates automatically at the end of the six-month period

and the case closes without worker action or notice to the client. In order to continue Medicaid coverage, the client must re-apply. This puts the client back into fee-for-service for one to three of the six months of eligibility, thus causing a break in the continuity of care.

The new rules will eliminate the automatic case closure and replace the closure with a re-determination process. The eligibility worker will have to take an action in order for the case to close. This revision maintains the medical home model for Medicaid clients. The initial six-month eligibility period usually consists of 90 days retroactive eligibility in fee-for-service plus three months in Managed Care. Although a re-determination process improves continuity of care, the initial certification period is administratively burdensome. The new rules initiate a less burdensome process by allowing the initial certification period to consist of the current month, plus five months forward, plus one, two or three months of retroactive eligibility (up to a nine month certification period).

Oklahoma will continue to work in close collaboration with the Health Care Financing Administration to comply with the reporting requirements under SCHIP.